HEALTH ENTITLEMENTS AND THE FEDERAL BUDGET

TESTIMONY BEFORE THE BUDGET COMMITTEE
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Mr. Chairman, Congressman Spratt, and members of the Committee, thank you for inviting me to discuss entitlement programs and the federal budget. My remarks will focus on the health entitlements—most prominently, Medicare and Medicaid, which are my particular area of expertise.

The Medicare and Medicaid programs loom large in discussions of the budget, both because of the resources they currently require and the greater resource demands they will make in the future. However, this committee's focus on fiscal concerns should not obscure two "truths" about these programs.

First, they make health care affordable and long-term care available for millions of older, disabled, and low income Americans who would otherwise lack access to care when they need it. Second, the fiscal challenges facing these programs reflect factors beyond their control—growth in the populations they serve (elderly, disabled and, for Medicaid, low and modest income families without health insurance) and in the nation's health care costs.

Cuts in federal funds or structural changes in the structure of federal financing (like arbitrary caps or fixed appropriations/block grants) cannot be justified as promoting efficiency or personal responsibility in the Medicare or Medicaid programs. On the contrary, they would represent an abdication of the nation's responsibility to care for its most vulnerable citizens.

Challenges and Choices in Medicare

In July, 2005, we will celebrate the 40th anniversary of Medicare's enactment. This program's explicit goal was to assure access to mainstream medical care for the nation's senior citizens—a promise later extended to some people with disabilities. Medicare has been enormously successful in achieving those goals, and is credited both with extending and enhancing life for older Americans and alleviating financial burdens on their families.

These achievements have not been inexpensive. Increases in program costs have been a significant concern from the program's inception. However, Medicare's record in containing health care costs has been as strong if not stronger than the record of private health insurance. Medicare and private health insurers purchase health care in the same health care system and face the same pressure to balance access to care against controlling the cost of care. Medicare has been a leader in promoting that balance, ahead of the private sector in adopting provider payment methods that promote value for the dollar in the purchase of care.

Although beneficiaries have benefited significantly from the access to health care that Medicare provides, they too have faced significant costs. Medicare benefits have been and, even with the newly enacted prescription drug benefit, will remain less

comprehensive than employer-sponsored insurance benefits. As a result, beneficiaries incur substantial out-of-pocket spending and in traditional Medicare have no "stop-loss" or ceiling to protect them against catastrophic costs. The typical senior is estimated to spend more than 20 percent of income on health care, to receive and supplement Medicare's benefits.

From its inception, Medicare has been financed through a combination of payroll taxes on the working aged population, premiums from beneficiaries, and general revenues. Part A resembles Social Security, with a payroll-tax-generated trust fund that is dedicated to financing its benefits. As is true with Social Security, the aging of the population will lead to shortfalls in this trust fund, as a larger number of older persons rely for financing on a smaller number of working-aged taxpayers. (Part A is the only part of Medicare to which the concept of shortfall applies; it makes no more sense to talk about shortfalls for general-revenue-funded portions of Medicare than it does to talk about shortfalls in defense spending.)

What makes Medicare's financing challenge different from Social Security's is the growth in its per capita costs, alongside growth in the number of beneficiaries. Health care cost growth is not a problem unique to Medicare, however. It is a problem facing the nation's entire health care system.

Securing the adequacy of Medicare financing (the Trustees estimate exhaustion of the trust fund in 2019) is an important policy objective. But any measure that reduces federal spending on Medicare without slowing growth in the nation's health care costs will undermine, not strengthen, the security that Medicare provides. Arbitrary caps on Medicare funding would not eliminate the costs of health care; it would simply shift them from the program to the individuals who need health care and their families. Moving from Medicare's guaranteed benefits to "premium support" or contributions to purchase private health insurance would similarly shift risk. Claims that more competition across health plans can slow cost growth have simply not been supported by the evidence. The strongest competition among health plans seems to be to enroll people perceived to have fewer and less costly health needs and to avoid (or disenroll) people with greater, more costly needs. In the absence of mechanisms to overcome this "selection" problem, government pays private insurers more to serve beneficiaries than it would under the traditional system, and individuals who need the most care receive insufficient support.

This problem would be exacerbated if government were to limit its contributions to premiums, regardless of the growth in health care costs. In these circumstances, not only would those needing the most care face the highest risk, but all beneficiaries would face the burden of even greater out-of-pocket spending. In other words, reliance on private plans does not contain health care costs; it shifts the risk of bearing them from Medicare to individuals and their families.

Medicare has been enormously successful in assuring access to mainstream medical care for its beneficiaries. Our goal should be to secure the protection it provides, not to shift risks back to the very individuals it aims to protect.

Challenges and Choices in Medicaid

July 2005 will also mark the 40 anniversary of enactment of the federal-state Medicaid program. As a safety net for low income Americans who otherwise lack health insurance and the nation's primary safety net for long-term care, Medicaid has become the nation's largest public health insurance program. In 2003, Medicaid provided coverage for 25 million children, 14 million adults (primarily low-income working parents), 5 million seniors and 8 million people without disabilities. In the absence of Medicaid, the vast majority of its beneficiaries would be uninsured—and lack the access to medical and long-term care that Medicaid provides.

Medicaid's protections, like Medicare's, come at considerable expense to federal and state governments. But cost growth cannot be attributed to Medicaid inefficiency. Rather than reflecting excessive payments to providers (Medicaid is criticized far more often for paying too little than too much), Medicaid expenditure growth typically reflects increases in the number and kinds of people it serves.

Urban Institute analysis of Medicaid spending between 2000 and 2003 illustrates the critical role of the Medicaid health insurance safety net. In this period of recession and rising health care costs, Medicaid spending increased by about a third—not because of expansions of eligibility or dramatic increases in payment. Rather, the increased spending reflected substantial increases in enrollment, as people's incomes declined and employer-sponsored health insurance disappeared. Without expansion of the Medicaid safety net, the nation would have an experienced an increase in the number of children without insurance and an even larger increase than otherwise occurred in uninsured adults.

Although three quarters of Medicaid enrollees are children or their parents, about 70 percent of Medicaid's expenditures are for low income elderly people. Low income people with disabilities do not qualify for private health insurance. And few Americans have insurance for long-term care—the costs for which exceed the incomes of most American families. Responsible for half the revenues received by nursing homes and providing full or partial support for more than half of all nursing home patients, Medicaid is the nation's only safety net for long-term care.

It is the Medicaid entitlement that makes Medicaid's safety net role possible. The entitlement means that the program serves any individual who qualifies for eligibility. To support these services, the federal government provides states open-ended matching funds: the more people who are eligible for service and the more services costs, the more states receive in federal matching funds; the fewer people eligible, the less states receive. Open-ended matching funds enable states to respond to increased need that comes with recession or public health emergencies or to support newly available treatments, like ever-improving AIDS medications. Medicaid covers an estimated 55 percent of persons

living with AIDS and 90 percent of all children living with AIDS. When the number of people affected increases or the costs of treatment rise, federal funds automatically increase to share the burden.

Concerns about the costs of Medicaid have historically generated policy proposals to limit this entitlement by imposing arbitrary caps on federal Medicaid payments or substituting fixed allotments or "block grants" for open-ended matching financing. Without offering a specific proposal, the President's budget, refers to a "modernized Medicaid system" that will give state greater flexibility to serve more people for the same amount of money—by changing delivery systems, targeting populations and providing "appropriate benefit packages". However, no creativity in delivery can offset likely increases in numbers of people in need and increases in the cost of services over which Medicaid has little if any control. With capped funds, states' ability to "flexibly" expand coverage--provide coverage to currently ineligible uninsured populations or continue to expand home and community-based long-term care services--will be hampered, not enhanced, given the need to cover the inevitably rising cost of existing obligations. Either that, or expansions will come at the expense of people already in need. Jeanne Lambrew's recent **Milbank Quarterly** analysis makes abundantly clear that replacing open-ended federal matching with fixed growth rates or allotments in federal spending will inevitably fail to provide funds adequate to meet changes in need or changes in cost, leaving people without care.

Indeed, with capped federal funds, "flexibility" is nothing more than a euphemism for cuts in protection that federal rules currently do not allow: creating waiting lists for enrollment, favoring some parts of states over others, charging even the poorest beneficiaries out-of-pocket payments for service, and limiting access to any and all services based on fiscal concerns. Previous proposals have limited new "flexibility" to Medicaid's so-called "optional" populations, keeping federal requirements in place for "mandatory" population groups—primarily poor children, and elderly and disabled people eligible for Supplemental Security Income (SSI) (that is, with incomes below 74 percent of the federal poverty level). Without these protections, coverage would likely decline for "optional" populations, which that include elderly and disabled people with incomes below poverty but above 74 percent of the federal poverty level, the majority of elderly Medicaid nursing home residents, pregnant women with incomes above 133 percent of the federal poverty level, near poor children and very poor parents. To states, coverage would become an option; to the affected population, care would remain a necessity.

Policy Prescriptions

President Bush has characterized Medicare as "the binding commitment of a caring nation." The same language should apply to Medicaid. Yet the administration has offered no proposals to secure these essential commitments.

Increasing health costs that affect Medicare and Medicaid along with the rest of the health care system cannot be addressed through caps on malpractice awards or the creation of "health savings accounts". Malpractice costs are estimated to account for

about two percent of all health care costs; caps hurt damaged patients and provide virtually no relief from health insurance costs (less than half a percent). Individuals cannot "own" responsibility for their own health care by managing limited accounts, when the bulk of health care costs are catastrophic and decisions driven by health care providers. Meager tax credits for the purchase of private health insurance policies can assure few if any of the 45 million uninsured Americans affordable and adequate insurance protection. And cuts in federal funds for Medicaid do not eliminate the costs of care to vulnerable populations; they shift the burden of bearing these costs to states and the population at risk.

In 2005, after forty years of experience with Medicare and Medicaid, we should recognize that investment of our collective resources to protect those among us who become ill or need long-term care enhances the quality of our lives and our strength as a nation. This is the time to renew and extend our commitment, not explore ways to abandon it.